Richard A. Harmetz, DDS
8899 University Center Lane, #180
San Diego, CA 92122
858/452-3636 Phone
858/452-5558 Fax

Welcome to our office!

Who may we thank for referring you to our office? _____

PATIENT INFORMATION

First Name:_____ Last Name:_____ Middle Initial:_____
Address:_____ City, State, Zip:_____
Home Phone:_____ Cellular:_____ Pager:_____
Fax Number:_____ Drivers License:_____ E-mail:_____
○I would like to receive appointment reminders via e-mail too.

Sex: ○Male ○Female Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed
Birth Date:_____ Age:__ SS#:_____ Drivers License:_____
Student Status: ○Full Time ○Part Time School:_____ City/State:_____
Employment Status: ○Full Time ○Part Time ○Retired
Employer:_____ Work Phone:_____ Ext._____
Preferred Pharmacy:_____ Pharmacy Phone:_____

RESPONSIBLE PARTY (Only if someone other than patient, i.e. parent)

First Name:_____ Last Name:_____ Middle Initial:_____
Address:_____ City, State, Zip:_____
Home Phone:_____ Cellular:_____ Pager:_____
Employer:_____ Work Phone:_____ Ext._____
Birth Date:_____ Age:_____ SS#:_____ Drivers License:_____

INSURANCE INFORMATION

Primary Insurance (if applicable):
Primary Insured Name:_____ Relation: ○Self ○Spouse ○Child ○Other
Primary Insured SS#:_____ Member ID#:_____ Primary Insured DOB:_____
Employer:_____ Address:_____ City,State,Zip:_____
Insurance Co:_____Address:_____ City,State,Zip:_____
Effective Date:_____ Remaining Annual Benefits:_____Remaining Annual Deductible: _____

Secondary Insurance (if applicable):
Primary Insured Name:_____ Relation: ○Self ○Spouse ○Child ○Other
Primary Insured SS#:_____ Member ID#:_____ Primary Insured DOB:_____
Employer:_____ Address:_____ City,State,Zip:_____
Insurance Co:_____Address:_____ City,State,Zip:_____
Effective Date:_____Remaining Annual Benefits:_____Remaining Annual Deductible: _____

CONTACT IN CASE OF EMERGENCY

Name:_____ Phone Number:_____ Relationship:_____
Physician:_____ Physician Phone:_____ Last Exam:_____